

PHYSICIAN STATE/COMMUNITY MATCHING LOAN REPAYMENT PROGRAM APPLICATION

ND Department of Health Division of Health Facilities SFN 18571 (8-2001)

			-				
			Dept. Use Only				
Telephone: 701.328.2894			File	File Number:			
Name of Physician							
Home Address	City	Sta	te	Zip Code	Home Phone		
Office Address	City	Sta	ite	Zip Code	Office Phone		
Social Security Number I p			I prefer to be contacted at ☐ Home ☐ Office ☐ Either				
Identify your specialty				· ·	-		
General Practice Family Practice General Surgery Internal Medicine							
Pediatrics Psychiatry OB/Gyn							
Other, please specify:							
TRAINING							
Medical School				Year of Graduation			
Internship				Year of Comp	lation		
mensmp				Teal of Comp	netion		
Residency				Year of Completion			
Post Graduate				Year of Comp	letion		
Certification Status				<u> </u>			
□ NDBME □ FLEX □ ECFMG □ Other							
Current Status							
☐ Chief Resident (Circle year: 1 2 ☐ Resident (Circle year: 1 2 3 4 ☐ Medical Director (Circle year: 1 2 ☐ Practice ☐ Teaching ☐ ☐ Other	5)						

State License	State		Year	License	Number	
Practice Experience	Location		Туре	Years		
Hospital Privileges	Location		Туре	Years		
	OUTSTANDING M	IEDICAL ED	UCATION LOAN	S		
Lender/Ac	ddress	Loan #	Amount	Balance	Balance Date Loan	
					Must Be Paid	
	0.70					
Are you in default on any le	oans? If yes, identify lo	an and amount.				
How much money are you	requesting? (You may r	request no more	e than \$40,000)			
Name of North Dakota community where you will practice			Date you will be able to begin			
Do you have a medical lice	ense in any state or count	ry other than N	Iorth Dakota?			
If yes, please specify.	,	, , , , , , , , , , , , , , , , , , , ,				
Are you currently in litigation? If yes, please explain.						
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Employer	MPLOYMENT HISTO	Addres			s Employed	

Do you	accept Medicare assignment?	Do you accept Medicaid assignment?				
Yes □	No □	Yes □ No □				
1.	Attach three letters of recommendation.					
2.						
3.						
4.	4. Include the attached Community Participation Form (SFN 50557) signed by a community representative stating the community will pay fifty percent of your loan repayment amount in exchange for 4 (four) years of full-time medical services.					
	SIGNATURES A	AND AFFIDAVIT				
The undersigned hereby makes application for a state/community matching physician loan repayment subject to the provisions of North Dakota Century Code Chapter 43-17.2 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health.						
Signature Date						
State of)						
	of) ss					
On this		, year, before me personally appeared				
who having been sworn states that to the best of his/her knowledge and belief the statements in the foregoing application are true.						
knowledge and benefitie statements in the foregoing application are true.						
		Notary Public				
	(Seal)	y commission expires				

Return the completed application to:

Mary Amundson
Department of Community Medicine
University of North Dakota
501 North Columbia Road
P.O. Box 9037
Grand Forks, ND 58202-9037